

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044355

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10889

FILED NOV 19 1962

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN Jennings	
c. FULL NAME OF (If NOT in hospital, give location) Missouri Baptist Hospital		d. STREET ADDRESS (If outside, give location) 9250 Hallsferry	
3. NAME OF DECEASED (Type or print) JAMES HIGGINS		4. DATE OF DEATH November 11th, 1962	
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/29/04
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) inspector		11. BIRTHPLACE (City and state or country) Scotland	
13a. FATHER'S NAME not known		14. NAME OF HUSBAND OR WIFE Jean Higgins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Jean Higgins, 9250 Hallsferry	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Thrombophlebitis - Pelvic DUE TO (b) 463x DUE TO (c) Left Extremity		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. Louis	
21. I attended the deceased from Oct. 18, 1962 to Nov. 11, 1962 and last saw him alive on Nov. 10, 1962		22. SIGNATURE (Degree or title) Everett R. Lemuel, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 11/14/62	
23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, 8319 Hallsferry		25. DATE RECD. BY LOCAL REG. NOV 13 1962	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.		27. DATE SIGNED 11/12/62	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert M. Murray

X

Licensed Embalmer No. 3749

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.